

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 86 STATE FILE NUMBER 0011861

VS 300
Rev. 4/59

0710

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

PLACE OF DEATH
a. COUNTY Morgan

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN Versailles

Length of stay in 1b
15 yrs

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Highway W.

Inside Limits
Yes ☒ No ☐

c. CITY OR TOWN Versailles

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
Highway W.

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First Middle Last
Jacob Calvin Wilson

4. DATE OF DEATH
Month Day Year
March 19, 1965

5. SEX
Male

6. COLOR OR RACE
Can.

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH
Mar. 12, 76

9. AGE (last birthday)
IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.
89

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)
La Cade Co., Mo.

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Berry Wilson

13b. MOTHER'S MAIDEN NAME

Louisa Hedrick

14. NAME OF HUSBAND OR WIFE

Nancy Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No

17. INFORMANT
Address
a Ephriam Wilson Versailles Mo.

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia

INTERVAL BETWEEN ONSET AND DEATH
2 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

ASHD 2 Asthma 3 Trigeminal neuralgia

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.
Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1964 to 3-19-65 and last saw him alive on 3-18-65
Death occurred at 3:45 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Jack Gunn MD

22b. ADDRESS

Versailles, Mo.

22c. DATE SIGNED

3-20-65

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE
3-21-65

23c. NAME OF CEMETERY OR CREMATORY
Versailles Cemetery

23d. LOCATION (City, town, or county) (State)
Versailles, Mo.

24. FUNERAL DIRECTOR

Midwest Funeral Home Versailles, Mo.

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

J. J. Washburn

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Raymond C. Foster

Licensed Embalmer No. 4626

P. O. Address Newville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.